

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6107

CERTIFICATE OF DEATH

06094

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Queen Anne</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Bordley</u> Last <u>Bordley</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>18 78</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u> | | 11. BIRTHPLACE (State or foreign country) <u>md</u> | | |
| 13. FATHER'S NAME <u>John Wesley Bordley</u> | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Rachel Washington</u> Address <u>Church Hill md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Organic Heart disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from <u>April 10</u> , 19 <u>58</u> , to <u>May 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>58</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. Henry Fisher</u> | | | ADDRESS (Street, city or town, state) <u>Centerville md</u> | | DATE SIGNED <u>5/6/58</u> | | |
| PHYSICIAN'S NAME (Type) <u>Edgar L. Lane</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/9 - 1958</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Colored Church Hill md.</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> | | | ADDRESS <u>Church Hill md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u> | | |
| | | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | |

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>NAME OF DECEASED <i>John Doe</i></p> | | <p>DATE OF DEATH <i>Jan 15 1900</i></p> | |
| <p>AGE <i>45</i></p> | | <p>SEX <i>Male</i></p> | |
| <p>PLACE OF BIRTH <i>New York City</i></p> | | <p>RESIDENCE <i>123 Main St, Boston</i></p> | |
| <p>CAUSE OF DEATH <i>Heart Disease</i></p> | | | |
| <p>DATE OF BURIAL <i>Jan 17 1900</i></p> | | | |
| <p>PLACE OF BURIAL <i>Greenwood Cemetery</i></p> | | | |
| <p>SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i></p> | | | |
| <p>SIGNATURE OF REGISTRAR <i>Wm. J. Hall</i></p> | | | |

RECEIVED BY THE REGISTRAR OF VITAL RECORDS
JAN 16 1900
BUREAU OF VITAL RECORDS
STATE HOUSE, BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6108

CERTIFICATE OF DEATH

06095

Reg. Dist. No.

| | | | | | | | |
|---|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) RFD # 1 | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Kent First Cornelius Middle Rural Last | | | | 4. DATE OF DEATH May 22, 1958 Day 19 Year | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 31, 1911 | | 9. AGE (In years last birthday) 46 yrs. | IF UNDER 1 YEAR Months 5 Days 11 Hours 57 Min. | IF UNDER 24 HRS. Hours 57 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - State Roads Comm. | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) USA | | |
| 13. FATHER'S NAME Clarence Cornelius | | | | 14. MOTHER'S MAIDEN NAME Essie McKenny | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-03-0421 | | 17. INFORMANT Va. Cornelius - Chestertown, Md. RFD 1 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO degeneration of heart muscle - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 year DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from Oct 21, 1957 to May 23, 1958 , that I last saw the deceased alive on February 30, 1958 , and that death occurred at 11:50 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE GEZA KORALEWSKI M.D. | | | | ADDRESS (Street, city or town, state) MILLINGTON MD. | | DATE SIGNED 5/24/58 | |
| PHYSICIAN'S NAME (Type) GEZA KORALEWSKI | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 27, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Chester Cem. | | 22d. LOCATION (City, town, or county) (State) Chestertown, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells | | | | ADDRESS Chestertown, Md. | | 24a. REC'D BY REGISTRAR MAY 26 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arden | | | |

CERTIFICATE OF DEATH

6448



Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

DECEASED

NAME [Handwritten: John Doe]

AGE [Handwritten: 45]

SEX [Handwritten: Male]

RACE [Handwritten: White]

DATE OF DEATH [Handwritten: Jan 15, 1948]

PLACE OF DEATH [Handwritten: Home]

Cause of Death [Handwritten: Heart Disease]

Physician [Handwritten: Dr. J. Smith]

Signature [Handwritten: J. Smith]

Witness [Handwritten: J. Doe]

Registrar [Handwritten: J. Doe]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6199

CERTIFICATE OF DEATH

06096

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kings Town</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Aubrey C.</u> Middle <u>Daly</u> Last | | 4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 12, 1909</u> |
| 9. AGE (In years last birthday) <u>48</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Brooklyn N. Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Josh. Daly</u> | | 14. MOTHER'S MAIDEN NAME <u>Marguerite Bouvier</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>047-07-7512</u> | |
| 17. INFORMANT <u>Anne Gray Daly</u> | | Address <u>Chestertown, Md. Box 344</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable Coronary Thrombosis</u> DUE TO (c) <u>Coronary Sclerosis and Insufficiency</u> <u>one year</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>2 minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure and old thrombosis (May 1957)</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>May 12</u> , 19 <u>58</u> ; that I last saw the deceased alive on <u>May 12</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert W. Farr</u> | | M.D. <u>Chestertown, Md.</u> DATE SIGNED <u>5/13/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert W. Farr, M. D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 15/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Drexil Hill, Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> | | ADDRESS <u>Chestertown, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6110 CERTIFICATE OF DEATH

Reg. Dist. No. 06097

| | | | |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Queen Anne</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES BRAD FORD DUDLEY</u> | | 4. DATE OF DEATH <u>May 27 1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 11 - 1897</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired by com</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Dr. Samuel C. Dudley</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Spear</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs Anna Dudley Church Hill</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>md.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 26</u> , 19 <u>58</u> , to <u>May 27</u> , 19 <u>58</u> that I last saw the deceased alive on <u>May 26</u> , 19 <u>58</u> , and that death occurred at <u>5:00</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. Henry Fisher</u> | | ADDRESS (Street, city or town, state) <u>Centreville md</u> | |
| DATE SIGNED <u>5/27-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. Henry Fisher</u> | | <u>Centreville, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>May 29</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Kane</u> | | ADDRESS <u>Church Hill, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u> | |

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| <p>1. Name of deceased: <u>John Doe</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Age: <u>45</u></p> | | <p>4. Date of birth: <u>Jan 15, 1900</u></p> | |
| <p>5. Place of birth: <u>New York City</u></p> | | <p>6. Date of death: <u>Jan 20, 1945</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | | <p>8. Immediate cause: <u>Myocardial Infarction</u></p> | |
| <p>9. Duration of illness: <u>2 weeks</u></p> | | <p>10. Place of death: <u>Home</u></p> | |
| <p>11. Signature of physician: <u>[Signature]</u></p> | | <p>12. Signature of registrar: <u>[Signature]</u></p> | |
| <p>13. Date of registration: <u>Jan 21, 1945</u></p> | | <p>14. Office of registration: <u>Baltimore</u></p> | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH RECORD ACT OF 1928.

RECEIVED JAN 21 1945

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6111

Items 13, 14, Filing 230 6-12-58 et

CERTIFICATE OF DEATH

06098

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Chester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u> | | d. STREET ADDRESS <u>R.F.D.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Florence</u> First <u>Duives</u> Middle Last | | 4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1917</u> <u>41</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafar work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>213-22-7542</u> | |
| 17. INFORMANT <u>Wright Chester</u> | | Address <u>Lenwood</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>hypertensive Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic insufficiency + stenosis</u> DUE TO (c) <u>Decompensation ascites anasarca</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>several months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>028.1</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>th</u> | | 20f. (City or town) (County) (State) <u>th</u> | |
| 21. I certify that I attended the deceased from <u>Febr. 23</u> , 19 <u>58</u> , to <u>May 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>58</u> , and that death occurred at <u>557</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D. | | ADDRESS (Street, city or town, state) <u>Stevensville</u> DATE SIGNED <u>June 2, 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u> | | <u>STEVENSVILLE MARYLAND</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>6-4-1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Chester Church yard</u> | | 22d. LOCATION (City, town, or county) (State) <u>Chester Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. Henry</u> | | 24a. REC'D BY REGISTRAR <u>Cambridge Md.</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>June 9 '58</u> | | | |

CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED <i>John A. Smith</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>65</i> | |
| 4. DATE OF DEATH <i>Jan 15 1918</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Heart Disease</i> | | 8. DISEASE OR INJURY <i>Myocardial Infarction</i> | | 9. MANNER OF DEATH <i>Natural</i> | |
| 10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i> | | 11. SIGNATURE OF WITNESSES <i>John B. Smith, Mary A. Smith</i> | | 12. SIGNATURE OF REGISTRAR <i>John C. Doe</i> | |
| 13. PLACE OF BIRTH <i>Baltimore, Md.</i> | | 14. DATE OF BIRTH <i>Jan 1 1853</i> | | 15. OCCUPATION <i>Teacher</i> | |
| 16. MARITAL STATUS <i>Married</i> | | 17. EDUCATION <i>High School</i> | | 18. RELIGION <i>Methodist</i> | |
| 19. PREVIOUS ILLNESS <i>None</i> | | 20. PREVIOUS SURGERY <i>None</i> | | 21. PREVIOUS TRAUMA <i>None</i> | |
| 22. PREVIOUS ALCOHOLIC DRINKING <i>Occasional</i> | | 23. PREVIOUS TOBACCO SMOKING <i>Occasional</i> | | 24. PREVIOUS DRUG USE <i>None</i> | |
| 25. PREVIOUS RHEUMATISM <i>None</i> | | 26. PREVIOUS GOUT <i>None</i> | | 27. PREVIOUS DIABETES <i>None</i> | |
| 28. PREVIOUS HYPERTENSION <i>None</i> | | 29. PREVIOUS BRONCHITIS <i>Occasional</i> | | 30. PREVIOUS ASTHMA <i>None</i> | |
| 31. PREVIOUS ANGINA <i>None</i> | | 32. PREVIOUS CORONARY DISEASE <i>None</i> | | 33. PREVIOUS PERICARDITIS <i>None</i> | |
| 34. PREVIOUS MYOCARDIAL INFARCTION <i>None</i> | | 35. PREVIOUS ATRIAL FIBRILLATION <i>None</i> | | 36. PREVIOUS VENTRICULAR FIBRILLATION <i>None</i> | |
| 37. PREVIOUS SYNCOPE <i>None</i> | | 38. PREVIOUS FURTHER INFORMATION <i>None</i> | | 39. PREVIOUS OTHER INFORMATION <i>None</i> | |
| 40. PREVIOUS SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i> | | 41. PREVIOUS SIGNATURE OF WITNESSES <i>John B. Smith, Mary A. Smith</i> | | 42. PREVIOUS SIGNATURE OF REGISTRAR <i>John C. Doe</i> | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06099

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brasoville</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balt.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto city (24) 03x-2</u> ✓ d. STREET ADDRESS <u>582-47th St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Chas- First a. Middle Staberkam Last</u> 4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>19 58</u> | | | | 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 16, 1901</u> 9. AGE (In years last birthday) <u>56</u> yrs. 10. UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gas electric Co.</u> 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>John Staberkam</u> 14. MOTHER'S MAIDEN NAME <u>Elishabeth Mock</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Adna Helthaus</u> Address <u>582 S. 47th St.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a. m. _____ p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <u>W. Fisher</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 20, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> | | 22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. Kane</u> ADDRESS <u>Church Hill, Md</u> | | | | 24a. REC'D BY REGISTRAR <u>W. Fisher</u> DATE <u>MAY 21 '58</u> | | 24b. REGISTRAR'S SIGNATURE _____ | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the City and Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06100

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>In Chesapeake Bay</i> | | c. LENGTH OF STAY IN 1b <i>?</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3501-4 ✓ | |
| | | d. STREET ADDRESS <i>3501 Bank St</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>PAUL</i> Middle <i>ROBERT</i> Last <i>HARTMAN</i> | | 4. DATE OF DEATH <i>MAY</i> FOUND <i>4</i> Day <i>4</i> Year <i>1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 29-1901</i> |
| 9. AGE (In years last birthday) <i>56</i> yrs. | | 10. IF UNDER 1 YEAR # UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Army</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Winchester Va</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Robert Hartman</i> | | 14. MOTHER'S MAIDEN NAME <i>Grace Cooper</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give year or dates of service) <i>WW II Korea</i> | | 16. SOCIAL SECURITY NO. <i>230-09-4582</i> | |
| 17. INFORMANT <i>Shelma L Hartman Baltimore Md</i> | | Address <i>3501 Bank St</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Drowning</i> 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell overboard</i> | |
| 20c. TIME OF INJURY Month, Day, Year <i>3:15</i> Hour <i>XXXX</i> p. m. <i>5/4</i> 1958 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Water</i> | | 20f. (City or town) <i>1 1/2 n. Miller's Island, Balto</i> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>W. Henry Fisher</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>W. Henry Fisher, M.D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>May 16-58</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i> | | 22d. LOCATION (City, town, or county) <i>Baltimore Maryland</i> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Inc -</i> | | 24a. REC'D BY REGISTRAR <i>MAY 18 '58</i> | |
| ADDRESS <i>Baltimore Md</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. Henry Fisher</i> | |

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------------------|--|-----------------------------------|--|------------------------------------|--|------------------------------------|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | | 4. Date of Death | |
| 5. Place of Death | | 6. Cause of Death | | 7. Manner of Death | | 8. Signature of Medical Examiner | |
| 9. Signature of Coroner | | 10. Signature of Registrar | | 11. Signature of Physician | | 12. Signature of Nurse | |
| 13. Signature of Undertaker | | 14. Signature of Burial Society | | 15. Signature of Cemetery | | 16. Signature of Funeral Home | |
| 17. Signature of Mortician | | 18. Signature of Embalmer | | 19. Signature of Crematorium | | 20. Signature of Other | |
| 21. Signature of Witness | | 22. Signature of Juror | | 23. Signature of Judge | | 24. Signature of Jury | |
| 25. Signature of Jury Foreman | | 26. Signature of Jury Clerk | | 27. Signature of Jury Stenographer | | 28. Signature of Jury Interpreter | |
| 29. Signature of Jury Translator | | 30. Signature of Jury Interpreter | | 31. Signature of Jury Interpreter | | 32. Signature of Jury Interpreter | |
| 33. Signature of Jury Interpreter | | 34. Signature of Jury Interpreter | | 35. Signature of Jury Interpreter | | 36. Signature of Jury Interpreter | |
| 37. Signature of Jury Interpreter | | 38. Signature of Jury Interpreter | | 39. Signature of Jury Interpreter | | 40. Signature of Jury Interpreter | |
| 41. Signature of Jury Interpreter | | 42. Signature of Jury Interpreter | | 43. Signature of Jury Interpreter | | 44. Signature of Jury Interpreter | |
| 45. Signature of Jury Interpreter | | 46. Signature of Jury Interpreter | | 47. Signature of Jury Interpreter | | 48. Signature of Jury Interpreter | |
| 49. Signature of Jury Interpreter | | 50. Signature of Jury Interpreter | | 51. Signature of Jury Interpreter | | 52. Signature of Jury Interpreter | |
| 53. Signature of Jury Interpreter | | 54. Signature of Jury Interpreter | | 55. Signature of Jury Interpreter | | 56. Signature of Jury Interpreter | |
| 57. Signature of Jury Interpreter | | 58. Signature of Jury Interpreter | | 59. Signature of Jury Interpreter | | 60. Signature of Jury Interpreter | |
| 61. Signature of Jury Interpreter | | 62. Signature of Jury Interpreter | | 63. Signature of Jury Interpreter | | 64. Signature of Jury Interpreter | |
| 65. Signature of Jury Interpreter | | 66. Signature of Jury Interpreter | | 67. Signature of Jury Interpreter | | 68. Signature of Jury Interpreter | |
| 69. Signature of Jury Interpreter | | 70. Signature of Jury Interpreter | | 71. Signature of Jury Interpreter | | 72. Signature of Jury Interpreter | |
| 73. Signature of Jury Interpreter | | 74. Signature of Jury Interpreter | | 75. Signature of Jury Interpreter | | 76. Signature of Jury Interpreter | |
| 77. Signature of Jury Interpreter | | 78. Signature of Jury Interpreter | | 79. Signature of Jury Interpreter | | 80. Signature of Jury Interpreter | |
| 81. Signature of Jury Interpreter | | 82. Signature of Jury Interpreter | | 83. Signature of Jury Interpreter | | 84. Signature of Jury Interpreter | |
| 85. Signature of Jury Interpreter | | 86. Signature of Jury Interpreter | | 87. Signature of Jury Interpreter | | 88. Signature of Jury Interpreter | |
| 89. Signature of Jury Interpreter | | 90. Signature of Jury Interpreter | | 91. Signature of Jury Interpreter | | 92. Signature of Jury Interpreter | |
| 93. Signature of Jury Interpreter | | 94. Signature of Jury Interpreter | | 95. Signature of Jury Interpreter | | 96. Signature of Jury Interpreter | |
| 97. Signature of Jury Interpreter | | 98. Signature of Jury Interpreter | | 99. Signature of Jury Interpreter | | 100. Signature of Jury Interpreter | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in grave event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6114

Items 8, 9 Film G229 5-10-58 et

CERTIFICATE OF DEATH

06101

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Queen Annes</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Annes</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sudlersville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sudlersville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>M.</u> Last <u>Kennedy</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1885</u> <u>May 15, 1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR: Months <u>11</u> Days <u>22</u> Hours <u>18</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Harrisonburg Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Dorsey</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Clinton M. Kennedy</u> | | 217 Pinehurst Rd. Fairfax <u>Wilmington, Del.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Corbolic Dilatation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Corn Sclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Small Arterial Sclerosis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>W</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>7</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 12, 1958</u> , to <u>May 6, 1958</u> . That I last saw the deceased alive on <u>May 6, 1958</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | DATE SIGNED <u>5/6/58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 8, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Woodbine Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harrisonburg Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Cullow</u> | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> | |
| ADDRESS <u>Wilmington Del.</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06102

| | | | | | | | |
|--|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u> | | | | c. LENGTH OF STAY IN 1b <u>4 years</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walraven Nursing Home</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> <u>1437.2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Walbert</u> Last <u>Rodney</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>August 21, 1875</u> <u>82</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>George Walbert</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Gertrude Faulkner</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | | | 17. INFORMANT <u>Walter Rodney Worton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arterial Sclerosis</u> (c) <u>Chronic myocardial</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | |
| 20f. (City or town) <u>Sudlersville</u> | | | | 20g. (County) <u>Kent</u> | | 20h. (State) <u>Md.</u> | |
| 21. I certify that I attended the deceased from <u>June 1955</u> , to <u>May 13, 1958</u> , that I last saw the deceased alive on <u>May 13, 1958</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>C. H. Metcalfe</u> | | | | DATE SIGNED <u>5/14/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>C. H. Metcalfe, M.D.</u> | | | | ADDRESS <u>Sudlersville, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/16/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cemty</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> | | | | ADDRESS <u>Still Pond, Md.</u> | | 24a. REC'D BY REGISTRAR <u>May 16 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>DeLoach</u> | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6116

CERTIFICATE OF DEATH

Reg. Dist. No. 06103

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> | | | | c. LENGTH OF STAY IN 1b <u>80 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>W.</u> Last <u>Thompson</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 15, 1868</u> | |
| 9. AGE (In years last birthday) <u>89</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Edward Warner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Baker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>Mrs. Agnes Thompson Chester, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>? yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 18</u> , 19 <u>58</u> , and that death occurred at <u>1:02 AM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u> DATE SIGNED <u>5/18/58</u> ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. <u>Stevensville, Md.</u> PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 21</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u> | | 22d. LOCATION (City, town, or county) (State) <u>Stevensville, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 20 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u> | |

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|--|
| NAME OF DECEASED [Faint text, possibly "JOHN DOE"] | | SEX [Faint text, possibly "Male"] | | AGE [Faint text, possibly "45"] | |
| DATE OF BIRTH [Faint text, possibly "1910-01-01"] | | PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."] | | OCCUPATION [Faint text, possibly "Teacher"] | |
| CITY OF DEATH [Faint text, possibly "Baltimore"] | | COUNTY OF DEATH [Faint text, possibly "Baltimore"] | | STATE OF DEATH [Faint text, possibly "Maryland"] | |
| DATE OF DEATH [Faint text, possibly "1950-03-15"] | | TIME OF DEATH [Faint text, possibly "10:30 AM"] | | PLACE OF DEATH [Faint text, possibly "Home"] | |
| CAUSE OF DEATH [Faint text, possibly "Heart Disease"] | | MANNER OF DEATH [Faint text, possibly "Natural"] | | MEDICAL ATTENDANCE [Faint text, possibly "Physician"] | |
| SIGNATURE OF DECEASED [Faint text, possibly "John Doe"] | | SIGNATURE OF WITNESS [Faint text, possibly "John Doe"] | | SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"] | |
| SIGNATURE OF CLERK [Faint text, possibly "John Doe"] | | SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"] | | SIGNATURE OF JUDGE [Faint text, possibly "John Doe"] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

| STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|--|--|--|---|---|---|--|--|---|---|--|
| Item 20 Film 230 6-17-58 ans | | | | | | | | | | |
| 6117 CERTIFICATE OF DEATH | | | | | | | | | | |
| Reg. Dist. No. 06104 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Q. A.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> | | | c. LENGTH OF STAY IN 1b <u>90yr.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — | | | | | d. STREET ADDRESS — | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Jacob</u> Last <u>Tolson</u> | | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1958</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 22, 1868</u> | | 9. AGE (In years last birthday) <u>89</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Jacob Richard Tolson</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Willie Lewis</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) — | | 17. INFORMANT Address <u>Wilmer Tolson--Chester, Maryland</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>903.0 Inanition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of left femur</u> DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>3 wks</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Legs gave away and he fell</u> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>5:30</u> a.m. <u>4/30/58</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Chester</u> | | 20g. (County) (State) <u>Q.A.</u> <u>Md.</u> | | |
| 21. I certify that I attended the deceased from <u>May 31</u> , 19 <u>58</u> , to <u>May 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>58</u> , and that death occurred at <u>8:35</u> M, from the causes and on the date stated above. | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. | | | | | ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u> | | | | | |
| PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u> | | | | | DATE SIGNED <u>5/17/58</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 20</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Stevensville, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar G. Kane</u> | | | | | ADDRESS <u>Church Hill, Md.</u> | | 24a. REC'D BY REGISTRAR <u>MAY 20 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6118

CERTIFICATE OF DEATH

Reg. Dist. No.

06105

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRICE</u> | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRICE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>PRICE</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>EDWARD</u> Middle <u>WALLS</u> Last | | 4. DATE OF DEATH <u>MAY</u> Month <u>28</u> Day <u>1958</u> Year | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WH.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 16 - 1889</u> |
| 9. AGE (In years, last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PAINTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOHN H. WALLS</u> | | 14. MOTHER'S MAIDEN NAME <u>ELLA BENNETT</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>GORDON WALLS</u> | | Address <u>PRICE MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion + infarct</u> DUE TO (c) <u>Artherosclerotic Cardiovascular</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>9 mo</u> <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kidney Stone Rt</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>April 15, 1957</u> to <u>May 28, 1957</u> , that I last saw the deceased alive on <u>May 23, 1957</u> , and that death occurred at <u>10:00</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Centreville, Md</u> DATE SIGNED <u>May 31, 1957</u> | | | |
| ACTUAL SIGNATURE <u>C. R. Bayton</u> | | M.D. <u>Centreville, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>C. R. Bayton MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>BURIAL</u> | <u>MAY 31</u> | <u>CHURCH HILL CHURCH HILL</u> | <u>MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> | | 24a. REC'D BY REGISTRAR <u>Church Hill</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u> | | DATE <u>JUN 4 '58</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6119

CERTIFICATE OF DEATH

Reg. Dist. No.

06106

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Queen Anne</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Church Hill</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Church Hill</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Gertrude</u> Last <u>Wright</u> | | 4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>58</u> | |
| 5. SEX <u>Fem.</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 11, 1881</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Frisby</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Griffin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>John Wright Church Hill, Md. RFD</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart</u> DUE TO (c) <u>Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 1, 1927</u> to <u>May 19, 1958</u> , that I last saw the deceased alive on <u>5/17, 1958</u> , and that death occurred at <u>10</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>H. H. McHenry</u> M.D. <u>Chilwee</u> <u>5/23/58</u> PHYSICIAN'S NAME (Type) <u>H. H. McHenry</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 24</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u> | | 24a. REC'D BY REGISTRAR <u>MAY 28 58</u> | |
| ADDRESS <u>Church Hill, Maryland</u> | | 24b. REGISTRAR'S SIGNATURE <u>Chilwee</u> | |

